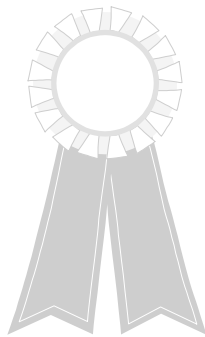


Blue Ribbon Panel Report To The Governor



September 2003

The Impact of The Labor Dispute at Northern Michigan Hospital on Health Care Services

September 18, 2003

David C. Hollister
Director
Michigan Department of Consumer & Industry Services
P.O. Box 30004
Lansing, MI 48909

Dear Director Hollister:

At the Governor's request, a Blue Ribbon Panel was convened to determine how the on-going labor dispute at Northern Michigan Hospital in Petoskey has impacted the delivery of adequate, safe, and affordable health care services in the counties served by the hospital. The attached report reflects our findings.

The fundamental principles that support the appointment of our independent panel are as follows:

- Hospitals, both public and non-profit, are community assets.
- The delivery of quality health care is in the public interest.
- Elected officials have an obligation to assure that adequate health care services in the immediate vicinity are readily available to the public.
- A protracted and acrimonious labor dispute has the potential of disrupting delivery of adequate health care services to Michigan citizens.

To get the most complete and accurate picture of the status of health care in the area, the panel welcomed input from a variety of community stakeholders by conducting two public forums, as well as a subsequent meeting with hospital officials. The panel also accepted letters, faxes, and e-mails from community members who were unable to attend the meetings. Finally, the Blue Ribbon Panel collected critical data from the Michigan Department of Community Health and the Michigan Department of Consumer and Industry Services that would allow us to determine how the health care situation in northern Michigan compares to the rest of Michigan and the nation, in general.

On behalf of the Blue Ribbon Panel, we would like to thank you and the Governor for the opportunity to serve the people of Michigan by examining this complex subject. Our work is not the final word on this topic but represents a significant step toward assessing the situation in northern Michigan.

One thing is certain after reading all of the testimony gathered on this subject -- whether or not community members, nurses, physicians, government officials, the Teamsters, and other community stakeholders believe there is a health care crisis in the region, all seem to agree that the health and viability of the hospital and community would be strengthened with the end of the labor dispute. Moreover, the Blue Ribbon Panel believes that a complete healing cannot occur unless many of the underlying issues raised by the nurses are addressed by a collaborative effort between the nurses, the Teamsters, physicians, hospital administration, and the Board of Directors.

Sincerely,

C. Patrick Babcock
Dr. Gloria R. Smith
Barry C. Brown

Blue Ribbon Panel

C. Patrick Babcock, Chair

- Former Director, Michigan Department of Social Services
- Former Director, Michigan Department of Mental Health
- Former Director, Michigan Department of Labor
- Former Research Professor, Wayne State University
- Bachelors Degree; Sociology; Western Michigan University
- Masters Degree; Social Work; Wayne State University

Dr. Gloria Smith

- Retired President of Programs; W.K. Kellogg Foundation
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- Former Director, Michigan Department of Public Health
- Former Dean of the College of Nursing; University of Oklahoma
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- Bachelors Degree; Nursing; Wayne State University
- Masters Degree; Public Health; University of Michigan
- Masters Degree; Anthropology; University of Oklahoma
- Doctorate in Anthropology; Union for Experimenting Colleges and Universities

Barry C. Brown

- Arbitrator
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- Former Director; Michigan Department of Labor
- Former Commissioner; Michigan Employment Security Commission
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- Former Commissioner; National Advisory Commission on Occupation Safety & Health
- Bachelors Degree; Business Administration; Wayne State University
- Law Degree; J.D. with distinction; Wayne State University

Report to the Governor by the Blue Ribbon Panel

The Impact of the Labor Dispute Northern Michigan Hospital On Health Care Services

Overview

Background

On November 14, 2002, nurses at Northern Michigan Hospital (NMH) in Petoskey, represented by Teamsters Local 406, went on strike in what has become the longest nurse's strike in the nation. Northern Michigan Hospital is both the largest employer in Petoskey and the largest health care provider in the region.

Mission

In response to the many appeals from leaders and residents in the Petoskey area to bring resolution to the labor dispute, Governor Granholm appointed an independent Blue Ribbon Panel to examine the implications of the current work stoppage on the delivery of adequate, safe, and affordable health care services to residents of Emmet County and other communities served by NMH.

The Blue Ribbon Panel was charged with preparing a report to the Governor based on the information gathered and presented to them, assessing such factors as:

- Quality of health care
- Accessibility of health care services
- Cost of adequate health care services
- Stability of the NMH census
- Recruitment of qualified medical professionals to the area
- Prompt delivery of acute medical services
- Impact on well-being of NMH community
- Ability to respond to medical emergencies (i.e., outbreak of infectious diseases)

Within the scope of their charge, the Panel also provided opportunities for community members to express their concerns through constructive dialogue relative to the labor dispute.

Methodology

The Blue Ribbon Panel held two public forums at North Central Michigan College on the following dates:

Thursday, July 10, 2003, 7:00 p.m. - 10:30 p.m.

Friday, July 11, 2003, 9:00 a.m. - 1:30 p.m.

The Panel also met with hospital administrators, physicians, and other representatives of NMH at North Central Michigan College on Friday, July 25, 2003, from 9:00 a.m. - 1:45 p.m. (See page 18, "Accountability to the Community," for a discussion on this meeting.)

The Panel met with a group of NMH physicians who asked for a private session at the Hampton Inn on July 10, 2003, from 5:00 p.m. – 6:45 pm.

The Mayor of Petoskey met with the Panel on Friday July 11, 2003, and individual sessions were held with two other members of the City Council.

Advertisements and press releases were run in several Northern Michigan newspapers, encouraging all stakeholders to attend the two public forums. People who were unable to attend the forums were encouraged to submit their comments in writing via mail, fax, and the Internet.

Approximately 557 community residents, hospital patients, striking and non-striking nurses, hospital administrators and technical staff, physicians, local government officials, and labor union representatives shared their comments and information with the Panel using one of the methods described above.

Written statements were received from both Teamsters Local 406 and NMH administration.

Supporting data was compiled by two state departments in order to provide a more comprehensive analysis. The Michigan Department of Consumer & Industry Services is the regulatory body overseeing the licensure of hospitals and health professionals regulated by the Public Health Code (1978 PA 368). The Department of Community Health is responsible for the collection of public information on a range of health related issues.

Findings and Recommendations

Findings

After carefully listening to the testimony of 105 Northern Michigan residents, considering the statements of over 470 residents who chose to communicate with us in writing and holding discussions with area public officials and health care providers, **the Panel has reached a primary and inescapable conclusion – the current labor dispute at Northern Michigan Hospital (NMH) has gone on for far too long.** With the notable exception of the NMH Board and administration, **the overwhelming sentiment of those who communicated with us called for the parties to return to the bargaining table to solve this dispute.** In our judgment, the residents of Northern Michigan have every right to expect both NMH and Local 406 to responsibly negotiate the remaining issues.

The Panel found indicators that the **failure to do so, to date, due in large part to the intransigent and ideological position of the NMH Board, has had serious and deleterious effects on NMH and the community.** NMH has long performed as a community asset in the health service delivery area that includes Emmet, Charlevoix, Antrim and Otsego counties. Of note, too, is the fact that all the other hospitals in Northern Michigan are unionized and no hospital in Michigan has an “open shop.”

Since November 14, 2002, **rather than acting as prudent stewards of this community asset, the NMH Board has authorized large additional expenditures to pay temporary nurses at premium rates, jeopardizing the hospital’s already precarious fiscal stability prior to the strike** -- an expenditure amount that the Board and administration have refused to release to the community or to the Panel.

NMH has long been considered a leader in the delivery of quality of health care. Yet the Panel heard disturbing examples of questionable health care practices during the strike from both former patients and licensed health professionals, both strikers and non-strikers. While NMH has denied these charges, **the number and significance of the complaints warrant additional independent review, particularly in the area of infection control and serious incidents involving patient care.**

While long regarded as a positive contributor to community life, **the NMH strike has divided the hospital staff and the communities in the broader NMH service area.** These divisions **will not be easily resolved – and any resolution will be much more difficult in the absence of a negotiated settlement and the return of the striking nurses to their role as health care professionals serving the community.**

The **Panel is optimistic that these issues can be resolved if both parties make a serious attempt to do so,** with the assistance of federal and state mediation.

Recommendations

The Panel respectfully recommends the following actions:

1. **MDCIS should examine all minutes of NMH's Infection Control Committee held between November 15, 2002, to the present date and all serious incident reports from November 14, 2002, to the present date.** NMH should provide MDCIS with a complete report of infection and other health quality indicators.
2. To strengthen fiscal stewardship within the community, **NMH should provide a public independent audit of all costs of temporary staff hired or under contract to fill vacancies resulting from the nurse's strike.** This hospital is a community asset and the public has a right to know the costs associated with the Board's actions and strategies.

To further stewardship with the community and promote better communications, NMH should publish its patient complaint review procedures. NMH should review each patient complaint received since November 14, 2002, and assure that the complainant has received a thorough response.

3. Further, the Panel recommends that MDCIS carefully review the testimony shared with the Panel by patients, their families, and medical personnel regarding cases of inadequate care. **If warranted, the state should not hesitate to seek a full state licensure and federal certification survey** using state and federal surveyors.
4. The Panel recognizes the devastating and divisive effect this dispute has had on the greater Petoskey community. It also recognizes that the dispute can only be resolved at the bargaining table. Therefore, **the Panel recommends that the parties immediately return to the bargaining table and, with the assistance of mediators from the Federal Mediation and Conciliation Service (FMCS) and the State's Bureau of Employment Relations, engage in intensive bargaining, particularly with respect to the three key issues: union security, management rights, and compensation. If, after 30 days, the parties are not able to resolve this dispute at the bargaining table, the Panel urges both parties to consent to binding arbitration.**

Census Information and the Status of Health Care at NMH

Census information

The following information regarding Northern Michigan Hospital (NMH) and Emmet County was provided by the Michigan Department of Community Health and the Northwest Community Health Agency.

Northern Michigan Hospital (NMH), a 243-bed regional referral hospital, which has been in existence for 102 years, is located in Petoskey with a primary service area including Emmet, Charlevoix, Antrim and Otsego counties.

See [Appendix 1](#) for a complete description of NMH services and census information for the region.

The hospital is accredited by the Joint Commission on Accreditation of Health Organizations (JCAHO) and its Cancer program is approved by the American College of Surgeons. It is a Rural Referral Center, certified to accept Medicare and participate in Blue Cross/Blue Shield.

A sizable proportion of the population in NMH's catchment area face significant economic and other barriers in accessing appropriate health care. For example, nearly 26 percent of the children in Emmet County receive medical coverage through Medicaid or MICHILD, the state federal health program for low-income children.

All four counties experienced generally higher than state or national unemployment rates during 2002. A growing part of the service area population is experiencing problems in obtaining health insurance coverage. The director of the Northwest Community Health Agency (NCHA) advised the Panel: "our principal employment base is service jobs, not manufacturing, and in service employment, health insurance is the exception (not the rule). When you look at the working population, they don't have insurance. They access the health care system late, at great cost, and without reimbursement. Uncompensated care is a major problem for hospitals and health care providers in the area. The hospitals and other health care providers have been partners in developing programs and taking care of people, whether or not they have access to insurance."

Using data from the 1990 census and comparing it to the 2000 census, Emmet County's population increased 25.5 percent, while the state population grew 6.9 percent. The director of the NCHA also stated, "this increase in population has resulted in an increase on the demand of our health care system, and it's going to continue to grow as the elderly people, the retirees that have moved to our area, place demands on the health care system."

See Appendix 2 for demographic data of the region, as provided by Kids Count in Michigan [2001].

Like many hospitals, NMH has also experienced major changes – and often reductions in reimbursement for services.

In 2001, the Regional Community Health Assessment and Improvement Plan by the NCHA noted the following:

“The impact of health care reform has been felt locally on many levels. Hospitals have been affected by two key issues. First, the Federal Balanced Budget Act of 1997 caused deep cuts in Medicare, which constitutes about half the area hospitals’ revenue (which corresponds to the higher number of retirees in the area). Secondly, the state has shifted its Medicaid caseload to managed care. Reimbursements are lower and are paid late. Reportedly, physicians in some communities are deciding not to participate with Medicaid, which will directly affect access to care for families, especially obstetrical care. Local health departments are affected by the same two forces through their Home Health and Hospice programs, which are dependent on Medicare and the Maternal and Infant Support Services program, which is dependent on Medicaid.

In 1999, a major reorganization of the health care delivery system occurred in Petoskey largely as a result of PhyCor, a for-profit management organization’s decision to no longer participate in Blue Cross/Blue Shield. Burns Clinic Medical Center disbanded, which required physician practices to become independent practices in the community or continue to be located in the Burns Clinic building with management services purchased through Northern Michigan Hospital.”

Representatives of the NMH administration advised the Panel that the termination of Burns Clinic resulted in NMH providing some compensation to some of the affected physicians.

Emergency Preparedness

According to testimony by the Chief Medical Executive for the Michigan Department of Community Health:

"Being prepared for the reintroduction or the possible reintroduction of smallpox has been something that we've been putting a great deal of time and energy in. Northern Michigan Hospital has participated with the local public health department to provide smallpox vaccination for a small number of its staff, and that's very helpful in a preparedness sense. But if there were to be an actual smallpox event somewhere in the state, and we found ourselves in a situation where we had to vaccinate essentially the entire population in a short period of time to protect them from this very dangerous communicable disease, we would have to call upon institutions like Northern Michigan Hospital to participate in those mass vaccination programs. And I dare say that the sort of assistance we would need from Northern Michigan Hospital would be very difficult in the face of the current situation."

The Nursing Shortage - A National Trend

Like hospitals across the nation, NMH has experienced shortages in nursing personnel.

Peter Buerhaus in “Shortages of Hospital Registered Nurses Causes and Perspectives on Public and Private Sector Action,” Nursing Outlook January/February (Volume 50, Number 1), states that hospitals have reported shortages in nursing since 1988. In July 2001, the American Hospital Association reported 126,000 unfilled full-time nursing positions in U. S. hospitals.

Prior to the current strike, according to testimony provided by one of the striking nurses, NMH experienced continual difficulty in filling professional nurse vacancies. Unfilled vacancies resulted in short staffing, which created stress on the nursing staff.

In an article published by Marc L. Colosi in the September 2002 edition of "JONA's Healthcare Law, Ethics, and Regulation," (Volume 4, Number 3), some of the reasons listed for the national nursing shortage include:

- Of the 2.7 million registered nurses, 20 percent or 540,000 nurses were not using their licenses.
- There are greater opportunities in other less stressful, career-expanding, stable, and perceived better work and family balance industries. Nursing is considered highly stressful, and there is an extreme work and family imbalance in the field (i.e., forced overtime, increased shift rotations, and elevated on-call and nurse floating requirements). (Note: More than 43 percent scored "high" on a Burnout Inventory assessment.)
- During the past 3 years, there has been a 22 percent decline in nursing school enrollments.
- The nursing population will reach an average age of 56 by 2005.
- There is a low image of the nursing profession, vis-à-vis other health care professionals.
- The average annual salary of \$46,832 per year (considered too low, as 57 percent of the nurses consider that salaries are inadequate).
- The short salary experience scales are capped on average at 7-10 years.
- The belief that hospital executives need to emphasize: investment in human (nurse) capital assets, return on investment (ROI), and return on human (nurse) capital investments, rather than just seeing "costs and budgets."

Nursing staff turnover is continuous, thus quite costly to hospitals. Colosi also states that according to the Saratoga Institute, Human Resources Financial Reports (Santa Clara, CA; 2001), institutions must determine the cost of RN turnover, which on a national basis ranges from two times the nurse's salary (\$45,832 X 2 = \$93,664) to \$145,000 per RN. The factors considered include:

- Advertising
- Interviewing (nursing and HR)

- Administrative time in HR (job posting, position control, referencing, and investigation screens, etc.) and nursing
- Union requirements
- Terminal pay outs
- Lost productivity and intellectual property
- Pre-employment physicals and drug screens
- Increased use of travel nurses
- Increased use of per diems
- Postponed elective surgeries
- Bed or unit closures
- Employment agencies
- RN orientation time
- Training costs
- Increased overtime
- Elevated incentives to work overtime
- Increased call-outs
- Elevated weekend rotations
- Elevated shift and floating rotations

A source of dissatisfaction for hospital nurses is the fact that they have not had sufficient control of their own practice. An article by Ward and Berkowitz, “Arching the Flood: How to Bridge the Gap Between Nursing Schools and Hospitals”, (Health Affairs, September/October 2002, Volume 21 Number 3), notes the following:

- Nurses moved wholesale from private duty to hospital care in the 1900s but did not collectively or authoritatively assume management of their own work.
- The American Nurses Association conducted a survey in 2001 asking nurses to describe their work environment. Seventy-five percent responded that the quality of nursing care in their hospitals had declined over the previous two years.
- An Institute of Medicine study on staffing adequacy shows that the proportion of RNs has a positive influence on severity adjusted Medicare mortality rates, as does a professional practice environment.
- A professional-practice environment was characterized by unit level self-management, participant decision-making, use of primary care nursing, peer review, and salaried status for RN staff.
- Magnet hospitals offer models that attract and retain nurses. These are characterized by effective and supportive leadership, nursing staff involved in hospital decision-making, commitment to professional clinical nurse qualities, participatory management, autonomy and accountability and a supportive environment.

According to testimony offered by the Administrative Director for the Michigan Council 25, AFSCME:

"The tendency to exploit health care workers has become particularly pronounced during the severe shortage of nurses in recent years, leading to mandatory overtime abuse, increased workloads, and other problems. While we are painfully aware of the shortage, we're also painfully aware that these management responses have only served to drive even more nurses from the field, aggravating the problem, rather than solving it."

To illustrate his point, the director cited two major nursing strikes in 2000 that involved mandatory overtime. In the District of Columbia, nurses struck the Washington Hospital Center and stayed out for 47 days. The primary issue was forced overtime. On November 8, 2000, nearly 600 nurses represented by AFSCME Local 875 and Council 25 and employed by McLaren Health Care Corporation in Flint, walked out. One of the major issues in this strike was, again, mandatory overtime and related on-call practices. For many who think the strike is "all about money," these cases illustrate the fatigue experienced by nurses stretched beyond the breaking point. They also illustrate the types of issues that lead health care workers to seek union representation in the first place.

He also noted the 1979 strike by health care workers (represented by AFSCME Local 2653 and Michigan Council 25) at St. Francis Hospital in Escanaba, Michigan. This historic strike lasted 120 days before it was settled with the assistance of a special mediation panel assigned by the Federal Mediation and Conciliation Services. The issues of this strike were not economic. The employer sought to take away union security language, creating an agency shop dispute.

Traveling Nurses - National Trends and Usage at NMH

Concurrent with the national nursing shortage is the trend across the United States in utilizing traveling nurses. Many nurses are leaving the single-employer hospital setting and signing on with traveling-nurse employment agencies.

The success of these employment agencies lies in their responsiveness to nurses' desire for autonomy and control over their work schedules. Also, nurses are able to demand compensation at higher levels, and gain support for a more flexible lifestyle. The lack of autonomy, little control over their own work environments, and inadequate salaries and benefits are reasons that drive many nurses toward unionization. Many nurses feel these entrepreneurial agencies offer benefits the hospitals have heretofore failed to deliver. These agencies also offer opportunities to travel, a selling point for many nurses. Further, better compensation serves as a substitute for loyalty to the hospital and good peer and professional relationships. If one is paid enough, one can overlook disrespect and fractious relationships encountered in short-term-work experiences of 2-13 weeks.

Although the Panel recognizes the benefits for using traveling/temporary nurses from the traveling nurses' standpoint, the Panel has been apprised of several studies that suggest adverse effects on patient safety and quality of care:

- Aiken, Sloane and Klocinski (1997) did find a 65 percent increase in the risk of needlestick injuries to non-permanent staff over permanent staff over a one-month period. The researchers believe that needlesticks may

be a proxy for a broad range of quality issues in hospitals related to non-permanent nurse staffing, including patient safety.

- A 1999 study of temporary staff in Pennsylvania hospitals points to a relationship of proportional quality of care indicators such as falls and medication errors linked to higher numbers of temporary nursing staff in those facilities.
- American Nurse Credentialing Center surveyors state that they are seeing a trend of decreasing use of traveling nurses across the country in the hospitals they are visiting. These are facilities that achieve the highest quality of patient care and that the research demonstrates have the greatest success of recruitment and retention of registered nurses.
- After an extensive review, one large Midwest system (with hospitals in 15 states including Michigan) made a strategic decision three years ago to decrease its use of traveling nurses. This decision was based on issues of building a system and institutional culture of quality and continuity of care through investment in recruitment and retention of permanent staffing. The financial savings are being utilized for recruitment strategies, offering support for all levels of staff to pursue additional education (RN to Bachelor's degrees, LPN to Associate Degrees in nursing, medical assistants for LPN and AND programs), recruitment of nurses who have been away from practice and offering refresher courses (including computer on-line programs). From \$45 million to \$60 million are being re-allocated annually from hospital travel nurse budgets to their employee programs. One hospital in Michigan has been able to totally eliminate its travel nurses over the three-year period.

According to NMH officials, 230 of approximately 460 nurses originally went out on strike (50 percent), but 10-23 percent of the striking nurses eventually returned to work. NMH has also hired 80 permanent nurses since the strike began, and traveling/temporary nurses comprise 33-40 percent of the workforce (approximately 150 nurses).

Prior to the strike, the hospital administrators reported that NMH typically hired 30-50 traveling nurses to augment their regular staff during the high summer season. The hospital states that the RN mix, nurse-to-patient ratios, and RN hours per patient per day are equal to pre-strike levels and that they do not foresee decreasing the RN mix or increasing ratios. Written testimony presented by the union challenged this assertion.

It is particularly difficult to get a handle on costs associated with using traveling nurses. The hospitals and the services that provide traveling nurses guard information on the costs for obvious reasons. First, the costs are indicators of the inefficiency of hospital care as a business enterprise. Second, the difference in rates and bonuses offer proof that the systems have sufficient resources to pay regular staff better salaries. (See page 20 for a detailed discussion of the Panel's assessment of the NMH's additional costs as a result of employing temporary nurses during the strike.)

Nurse Training and Internship Programs

The rotations of North Central Michigan College (NCMC) nursing students at NMH have been discontinued by the college during the current labor dispute. This is not surprising since there are compelling reasons for not placing students in a situation in which the stability of the learning environment is questioned. Students are placed on clinical rotations to learn; they are not qualified to substitute for RNs. Student assignments for patient care are adjunctive in that the primary responsibility for the patient is always assigned to licensed staff. In effect the student shares the patient assignment. It is an expectation that staff RNs will assist the faculty in clinical supervision of students through demonstration, observation and frequently direct supervision of specific tasks and procedures. This model of shared responsibility for clinical supervision is predicated on the fact that quality patient care and patient safety are the highest priorities; these responsibilities are vested in the staff nurse. The staff RNs serve as positive role models; a student learning from negative experiences is not an objective. In a strike situation in which a significant percent of the staff are traveling nurses, the orientation is truncated. Further in this particular situation, there is some question about the adequacy of RN to patient ratios. The staff of NMH may well be too stretched to take on the added burden of assisting with clinical teaching.

Training future nurses requires huge public investments as well as significant personal investments. Clinical training experiences help students either to firm a commitment to practice nursing or decide to change careers. NMH offers a rich mix of clinical diagnoses and interventions among the patients who are served. Many people commented that the student nurses benefit greatly from their clinical experiences at NMH. It does not appear however that NMH provides an environment that supports the professional practice of nursing inherent in the magnet hospitals: effective and supportive nursing leadership, nursing staff involvement in hospital decision making, participatory management, autonomy and accountability. NMH must consider that being the only game in town is not sufficient reason for clinical placement.

During the July 24-25 open forums and in discussions with physicians and nurses, the Panel heard numerous statements alleging that NMH temporary nurses were not receiving appropriate orientation. Both health care practitioners and former patients gave examples including a lack of familiarity with hospital procedures, inability to locate needed supplies, failure to connect and monitor medical equipment and IVs and poor communication with patients during the delivery of health care services.

During her testimony on July 25, NMH's Chair of Nursing told the Panel that current orientation of traveling nurses consists of both classroom and precepted time on the unit. The time varies according to the unit and the skill level required.

The current practice appears to deviate from pre-strike practices. We have been informed that prior to the strike, a new RN at NMH would receive six to eight weeks of precepting. A senior and currently striking NMH nurse who had served as a preceptor provided the Panel with a detailed and specific statement concerning the quality and extent of previous orientation in contrast to vague defense by NMH administration concerning current practices.

Health Care Information and Perceptions Shared With the Panel

The following represents a summary of comments received by the Panel from 557 individuals during the course of our forums and other work:

- The period of greatest health care risk may have occurred in the first weeks of the strike, as the strike impacted the hospital unevenly. Most of the Operating Room nurses went on strike, while most of the Emergency Room nurses remained. Personnel were shifted around, and traveling nurses were new to their surroundings. Many of the reports of poor care came from this period, and many of the negative reports came from post-operative situations. Hence, the strike impacted certain areas of the hospital more than others, and the hospital claims it has implemented policies to stabilize the various units within the hospital. Further, the hospital claims that no surgeries or procedures have had to be cancelled or patients diverted due to the strike.
- The Panel also heard from several physicians and other NMH personnel, who wish to remain anonymous for fear of reprisals, about some very serious incidents that continue to put patients at risk and are a direct result of changes at the hospital due to the strike.
- According to testimony received at the public forum by a former CEO of NMH, “we’ve got a fractured physician community, a fractured nurse community, and a fractured organization...and the community is fractured.” He further stated, “I have no reason not to believe” the stories shared by others regarding quality of patient care concerns.
- The hospital claims that the quality of patient care has not diminished during the strike. They claim the replacement and traveling nurses are extremely skilled, and, in some instances, are more skilled than their permanent or striking counterparts. There is little reason to challenge their judgment that the traveling nurses were highly skilled. What is known, however, about utilization of traveling nurses is that too often they do not have time to become sufficiently oriented to new environments. Since hospitals are each unique, the lack of adequate orientation time is problematic. Traveling nurses do not know where to locate or how to use essential equipment; are not conversant with specific protocols; and, are unfamiliar with routines of individual physicians. The Panel heard a number of complaints that were related to lack of timeliness to respond that were directly related to inadequate orientation of traveling nurses. A corollary to the increases in traveling nurses appeared to be a reduction in the numbers of RN staff. Several studies document that inadequate RN staffing increase outcomes that are particularly sensitive to nursing, i.e., urinary tract infection, pneumonia and shock. (Ward & Berkowitz; Health Affairs; “Arching the Flood: How to Bridge the Gap Between Nursing Schools and Hospitals,” September/October 2002.)
- NMH monitors the infection rates at the hospital, and the hospital claims there has not been an increase in occurrences since the strike. However,

the May 21, 2003, minutes of NMH's Infection Control Committee reports significant increases in urinary tract infections, viral acquired pneumonia and bodily substance incidents rates for ICU patients in the first quarter of 2003. The BSI rate is reported as "the highest that NMH has experienced."

- During the public forum and in written testimony there were a number of complaints that could be labeled as outcomes particularly sensitive to nursing. The chief nurse reported on the tracking of these indicators and seemed satisfied that there had not been increases. The hospital should feel challenged to corroborate these findings by retrospective studies conducted by independent investigators. Look-back studies of two or three time periods would give more credence to the hospital's assertion that patient care has not deteriorated. Although the hospital spoke favorably of the great qualifications of the traveling nurses it retained from the U.S. Nursing Corporation, it is no longer using those nurses due to their high cost. (The hospital reported that their average contracts ranged from 2-4 weeks.) What is known about U.S. Nursing Corps (FastStaff) is that ordinarily nurses are guaranteed six weeks of work in which they earn \$20,000.00. The hospital now uses traveling nurses from local agencies whose contracts range from 13-26 weeks. Although these nurses are paid less, their salaries are still higher than regular staff. They may or may not be less qualified. There will undoubtedly continue to be difficulties in training and orienting a constantly changing temporary workforce. Although the non-striking nurses deny any resentment toward traveling nurses who earn higher salaries for the same work, this assertion has a hollow ring. It is not easy to have a generous spirit toward a constantly changing higher paid workforce when they add to your own workload.
- Many people, whether in support of the nurses or believing the health care warnings made by Teamster-sponsored ads, striking nurses, etc., advised the Panel that they refuse to go to NMH for non-emergency, elective services. It is noteworthy that the NMH CEO advised the Panel on July 25, 2003, that the current available beds at NMH totaled 180, a decrease from the 213 beds reported to the state at the end of 2003. Indeed, solidarity and fear are causing many people to take their business elsewhere.
- The letters received following the forums told another story. The majority of incoming letters and email, received from working nurses, physicians, hospital administrators, patients, and their families, told of the great service and care patients had received by the non-striking working nurses, replacement nurses, and traveling nurses. In fact, many respondents reported that services had improved since the strike.
- What seems clear is that both the striking and non-striking nurses feel that they are taking the proper course of action. Both sides represent

themselves as persons with strong professional identity, strong commitment to quality patient care, and a strong sense of ethics. The non-striking nurses express deep conviction for quality patient care by ensuring uninterrupted care under difficult conditions. The striking nurses believe that without voice and opportunity to have input on hospital decisions that affect patient care, they continue to compromise quality care. Some of the non-striking nurses appear to be torn between the two positions and express a desire for an outcome that will bring both sides back to the bargaining table. Several of these nurses also expressed a desire for regulations that would ban work stoppage of “essential services.”

- Hospital representatives, after being admonished by public forum attendees and the press for not attending the public forums, invited the Panel back for a private meeting in which a different perspective was shared. The perspective shared by each attendee resonated in favor of the hospital administration's position and actions. The Panel received considerable negative feedback from other hospital representatives and affiliates who claimed they were not allowed to attend the meeting because their views varied greatly from those in attendance. Further, many accused the hospital of "stacking the deck" by inviting to the private meeting only the physicians who have a financial tie to the hospital, thereby having a financial disincentive for speaking out against the hospital. Conversely, many of those who attended the meeting claimed they did not feel safe sharing their pro-hospital sentiments at the public forums or in an open meeting setting, which is why they insisted on meeting in private. The same fears were echoed in much of the correspondence received by the Panel from several nurses and physicians currently employed at NMH. People feared their property would be damaged, their homes and businesses picketed, and their families harassed. Yet at no point was the Panel ever provided evidence that an individual had been attacked or homes vandalized or damaged.
- Many of the letters received regarding the status of health care did not directly attribute mistakes and poor care to the strike itself. Rather, their comments were an indictment of the status of health care everywhere. Nursing shortages, the high cost of medical malpractice insurance, and shrinking insurance reimbursements were suggested as root causes of inadequate health care.
- Information received from the Michigan Department of Consumer & Industry Services, Bureaus of Health Systems and Health Services, did not show a significant increase in the number of NMH complaints received or its professional staff when comparing data gathered prior to and during the strike. During the past two years, there were a total of seven complaints filed against Northern Michigan Hospital, some of which had multiple allegations. There were three complaints filed before the strike began and four complaints filed after the strike began. None of

the allegations in the four complaints filed subsequent to the strike were substantiated sufficiently to support a conclusion of non-compliance with operating standards. The state regulatory official has advised the Panel that while their reviews indicated that NMH had appropriate patient care procedures in place, the investigations did not rule out the validity of individual complaints, such as those received through testimony.

- The hospital reports that it joined the National Center of Nursing Quality, a national effort sanctioned by the American Nurses Association to benchmark quality nursing care in the United States.
- The hospital also touted the implementation of Bridge Medport two years ago, a computerized medication delivery system that not only documents delivery, but also helps prevent errors. This system has prevented thousands of errors since its implementation two years ago.
- Whether or not comments received directly link improved or worsened health care services to the strike, one thing is for certain, according to many respondents. Since perception equals reality in many cases, all seem to believe the health of the community will improve with a mutually agreeable resolution. It may simply be that the end of the strike will set the stage for healing.

Stewardship

NMH as a Community Asset

Nonprofit health care institutions have long been regarded as community assets, for both the communities that they serve and the state. As tax-exempt organizations, nonprofit hospitals receive important, albeit sometimes indirect, subsidies from the citizens of the community in which the facility is located, as well as the state. In turn, tax-exempt hospitals have an obligation to provide community benefits, often in the area of charitable care and health education and promotion services, to the communities that they serve.

In 1977, the incorporators of NMH, through the merger of Little Traverse and Lockwood McDonald hospitals, recognized the new institution's role as a community asset by requiring that in the event of NMH dissolving as a nonprofit corporation, all assets, after debt and obligation, go (in order of succession) to:

- Healthshare if in existence as a public charity;
- Healthshare's successor if a public charity;
- a public charity designated by the Board;
- the city of Petoskey.

The Panel has read the by-laws of Northern Michigan Hospital and acknowledges the forward-thinking values contained therein. The Board of Directors and their agents, the CEO and other officers, have a clear responsibility to provide stewardship for both the mission and resources of the nonprofit hospital. While good business practices are expected in that stewardship, the duty of the Board and officers goes beyond running a business.

The Panel heard testimony about three areas concerning the current stewardship of the hospital:

1. **Accountability to the Community:** Many who testified or otherwise communicated with the Panel criticized the current board and NMH administration for failing to meet with the community to inform the community of the full implications of the strike, particularly the fiscal implications. The Panel experienced the difficulties in gaining audience with the hospital first hand. Despite repeated invitations, the hospital board and administration refused to either acknowledge our invitation or to participate in the open community forums held on July 10 and 11, 2003. Instead they chose to deliver a 7-page non-specific statement to each panel member's hotel or home, at the time that the Panel was holding the first forum. It was only after a report of the Panel's frustration by the Petoskey News Review, that the NMH CEO invited the Panel to return to Petoskey for a closed session with representatives of the Board, administration, nursing and medical staffs, and patients. While the Panel was pleased to have the opportunity to hear directly from NMH, our conditions for that session were that the discussion would be on the

record and that the Panel would raise direct questions to the material that would be presented – conditions that were acceptable to NMH. The Panel was surprised that NMH chose to have two security guards present during the July 25, 2003, session. This was puzzling since no guards were necessary at the much more widely publicized and attended public forums. In spite of that unnecessary act by NMH, the Panel felt that it was important to engage directly with NMH officials and decided to proceed.

In testimony given at the public forum, the Chairman of the Board of Commissioners in Chippewa County, and trustee on the Board of War Memorial Hospital in Sault Ste. Marie, recalled negotiations with the same firm representing NMH in this negotiation. In one of the firm's first presentations to the Board, a strategy for keeping the hospital union-free was advanced. The firm was very quickly informed that this was not the position of the Board, as it was hired to negotiate a fair and equitable contract for both sides. According to the Chairman's testimony, the firm "changed positions and negotiated a fair and equitable contract that has worked well."

This story lends credibility to the suggestion that the hospital Board is willing, as a calculated strategy, to do whatever it takes to keep NMH union-free. The community deserves to clearly understand the charge of the law firm representing the hospital.

2. **Provider of Community Benefits:** NMH and its predecessor organizations have long been acknowledged as providing a high level of services to the broader community. The Panel heard important testimony from the Northwest Community Health Agency director that the strike has had a toll on that admirable record. He described NMH as a great partner with other health organizations in planning and developing needed programs and in taking care of residents without adequate insurance. He went on to state that the strike needs to be settled. The community cannot afford the distraction or the waste of community resources, both in the form of dollars and the talents of skilled professionals.
3. **Fiscal Stewardship:** A primary responsibility of the Board and officers of NMH is to protect the assets of the institution through fiscal policies. As is the case with many hospitals in the United States, prior to the strike, NMH's operational budgets were in a precarious position. For the last two years, data is available through state government agencies that show NMH lost millions of dollars in the provision of patient care services. In 2000, the hospital experienced a deficit of \$14,276,009 in net income for services to patients and had an overall net deficit of \$1,980,715.

In 2001, NMH had a better year, losing \$8,951,509 in net income for patient services, but realized an overall profit of \$1,357,255 (a net operating profit margin of 1.6 percent according to a February 14, 2002,

memo from the NMH administration to staff). While these years reflect both the challenges that NMH experienced and the effort that they have taken to increase direct care reimbursement revenue, actions since the strike began on November 14, 2002, have a significant negative effect on the solvency of the hospital. This impact is in two areas:

- **Patient Census:** The Panel heard a number of comments at the open forums and via other communications that former patients at NMH were seeking services from hospitals in surrounding communities. The NMH CEO and other senior staff disagreed with those comments on July 25, 2003. The CEO noted that the regional health is growing. “Everyone is busier. ...But we’re full, everyone is full.”

As the census data for hospitals in or near the NMH service area are not available for the period of strike, it is not possible for the Panel to accurately determine which side of this argument is correct. However, later in his testimony, the NMH CEO acknowledged that NMH has reduced its operation bed count from 213 as reported by state agencies in 2001 to 180 in July 2003, a 15 percent decrease in a growing health care market. This information may suggest that the NMH market share is being eroded, perhaps as a result of the strike.

- **Increased Staffing Costs:** The cost of employing traveling nurses depends on their specialty, their experience, and the staffing agency. The fees for traveling nurses in Michigan range between \$47-78 per hour, according to information gathered by the Michigan Health Association. The fees also vary, depending on the benefits given to the nurses by the agency. Some agencies provide 401K plans and health benefits; others simply provide an hourly wage.

According to NMH, the average annual base wage for a two-year degreed full time NMH RN is \$51,126. This base wage includes educational, team leader, and float incentives. Nationally, the average annual base wage is \$46,500. (*Nursing 2003*, Vol.32, No. 4) The hourly NMH range is \$18.79 to \$27.11 (annually, \$39,083-\$56,389). The average hourly rate for permanent nurses at NMH is \$24.40.

Also, according to NMH, in spite of the labor dispute and impasse, NMH implemented the following wage and benefit provisions in order to remain competitive:

- 3 percent market adjustment increase, effective February 23, 2003

- 3 percent market adjustment increase, effective June 15, 2003
- Clinical Advancement Educational Incentives
- New Team Lead and Float premiums
- Increased weekday hourly shift differentials (\$1.50 weekdays; \$1 and \$2 - weekends)
- On call premium increased to \$2.75 per hour
- \$1,800 per year in tuition reimbursement
- Enhanced funeral leave benefits
- New paid adoption leave provisions
- No inflationary increases in the cost of benefits passed on to working employees during 2003, except for age or wage related changes

The hospital would not provide the Panel with information and data to show the bottom line impact of paying 40 percent of its nursing staff (travelers) a premium wage versus what it would be paying if these nurses were permanent and working for the average hourly wage paid to permanent nurses (including benefits which average approximately \$11,000 per year). This information raises a very important question as to the hospital's willingness and ability to continue to pay premium wages. The community is concerned that a prolonged impasse at NMH would result in another Burns Clinic scenario, since many people see parallels between the two situations. Testimony shared with the Panel suggests a parallel between the inflexible behavior and decision-making of both boards.

The decision by NMH to hire temporary nurses, first through the U.S. Nursing Corporation and more recently through several Midwest organizations; has had costly implications to NMH's already uncertain fiscal position. At the NMH session, the CEO acknowledged that the contract with U.S. Nursing was costly but indicated that the traveler nurses contracts were more reasonable and that the "incremental costs of the strike are behind us." When asked about those incremental costs, he indicated, "I haven't worked the numbers. I don't know what they would be, but it is really not that significant." To date, NMH has not provided specific information either to the Panel or to community members who have requested it.

In a report prepared by the Teamsters Local 406, they estimate the net difference in costs to NMH for using replacement nurses between November 14, 2002 and July 14, 2003 is \$8,988,000.00. (See [Appendix 3](#) for details.) It is interesting to compare this amount to the amount of loss

reported in 2001 (see chart below) for "Net income from services to patients." The amount the Teamsters estimate the hospital is spending to hire temporary nurses is 6.6 times the amount of net income the hospital reported in 2001 (\$1,357,255).

Many people cannot understand how the hospital can register losses in net income from patient services and continue to spend 6.6 times their 2001 net income. This strategy, although working in the short run, can seriously strain NMH's finances and its ability to delivery health care services in the long run.

NMH Income	2000	2001
Inpatient Revenue	\$94,149,467	\$102,744,960
Outpatient Revenue	\$72,977,002	\$81,858,991
Total Patient Revenue	\$167,126,469	\$184,603,951
Net Patient Revenue	\$92,195,268	\$105,740,213
Total Operating Expenses	\$106,471,277	\$114,691,722
Net Income from Services to Patients	(\$14,276,009)	(\$8,951,509)
Total Other Income	\$12,448,945	\$11,008,727
Net Income	(\$1,980,715)	\$1,357,255

Data provided by the Michigan Department of Community Health

The continued failure of NMH to provide a full account to community of these and other costs of the labor dispute is unfortunate and certainly does not speak well for the NMH Board and officers' fiscal stewardship.

Other Economic and Financial Data - The Cost of the Strike

NMH has recently completed a \$15 million fundraising campaign to raise money for a new \$25 million addition that will house a new emergency department, heart and vascular center, and a patient rehabilitation unit. It plans to borrow the remaining \$10 million since, according to administration and board officials, interest rates are so attractive right now. (See Appendix 4 for more economic data about NMH, as provided by the Michigan Department of Community Health.)

Economic Information and Perceptions Shared With the Panel

The following represents a summary of comments received in testimony to the Panel:

- Although many people did not think health care costs had been impacted at all, others spoke of the "costs to the community." Fewer working nurses meant fewer dollars spent by their families in locally owned businesses. Many believe that the traveling nurses don't spend

their money in the community. Their big purchases are made elsewhere and benefit those local economies.

- Several people suggested the Governor request the IRS or the Attorney General to conduct a financial audit of NMH, as many of them questioned whether or not a non-profit organization can divert money raised and donated for the purpose of building a new wing (or buying new technology) to fund the prolonged use of traveling nurses (who receive higher wages, lodging and food expenses, etc.). Also, according to one respondent, the "sale" of a hospital office building to the NMH Board Chair was done without open bidding, which indicated poor stewardship of the hospital's assets.

According to a representative of the Board of Directors, no Northern Michigan Hospital Foundation money has been diverted to handle the impact of the strike. Foundation monies have been used for capital expenditures, but not operational costs.

Role of Communications in Stewardship

Many of the people who met with or wrote to the Panel, including members of the current hospital administration, noted there have been communication problems at NMH. Lack of communication was underscored in the testimony of many respondents, as well as lack of support and respect for the nursing staff. While some attempts have been made to improve communications, many of the key leaders at the hospital remain the same. Good communications is a key to effective stewardship. If the communication process is not improved and nurses have no effective management voice, the same problems that led to three elections for union representation will persist.

It was puzzling that several complaints addressed the failure of the hospital to respond to written letters of complaint. The hospital asserted that it is their policy to respond to all written complaints. Could it be that the responses are too general and not viewed as being specific to the registered complaints?

In 1995, the nurses adopted a shared-governance structure for nursing. The Nurse Executive Committee, the Professional Practice Council, and the individual Unit Based Councils have continued to operate since the strike began; however, opinions of whether or not these bodies were effective vary. The hospital reported that approximately 20 percent of the nursing staff participates in this governance structure. The model of shared governance is laudable and highly desirable if it is implemented. It seems, however, inconceivable that such a model was being implemented when nursing apparently had no or limited voice in senior management decisions.

The hospital is currently searching for a Vice President of Nursing. However, it does not appear reasonable that there has been no senior nurse executive for three years. The hospital currently has a Respiratory Therapist who has worked her way up through the ranks to the executive position of Director of Patient Care Services, to whom the hospital's lead nurse reports. This position oversees management and financial issues, while the lead nurse is in

charge of the clinical and professional aspects of nursing at the hospital. The chief nurse leader sits on the Board as a non-voting member.

There was a nurse on the NMH Board until 1999, when she resigned without explanation. It is not unusual in hospitals to have a structure where the senior nurse executive sits as a non-voting member of the Board. It is, however, quite remarkable that there is no nursing voice at the senior level of management at NMH. No matter what the hospital claims about searching for such a person, it seems clear that nothing is likely to change. The assumption that a new chief nurse would not expect to make changes is fascinating. Yet in her response to the Panel, the current clinical nurse leader expects to remain in her position with the same responsibilities. This would hardly signal a change to the nurses who are seeking more participation in hospital decision-making, greater respect for their work and new leadership.

Additional Stewardship Information Shared With the Panel

The following represents a summary of comments received in testimony to the Panel:

- The new management team has been in place for the past two years. The current CEO/President has served in this position for approximately one year. The hospital also has new executives in the areas of finance and human resources. Many former board members, surgeons, and others have stated that there is a strong Board of Directors in place, a board people are unable to stand up to for fear of being removed from the board or fired from the hospital.
- Many attendees of the public forums, representing mainly pro-nurse and anti-hospital sentiments, believe the hospital has been less than forthcoming with information and is unwilling to negotiate with the Teamsters. People also complained about the hospital's unwillingness to respond to the public's letters and complaints.
- The difficulties in hearing polarized versions of the issues surrounding the strike, is that heightened emotions associated with each version take on a life of their own. A long unsettled dispute can cause grief, anger and hysteria within a community that only polarizes and magnifies every action taken by each party within the dispute. This polarization and magnification will only continue to grow unless there is a resolution to the labor dispute and not a long-term extension of the standoff.

The Strike

Current Status of the Labor Dispute

August 13, 2003, marked the ninth month of the labor dispute at Northern Michigan Hospital. There continues to be three major sticking points in the impasse:

- The Teamsters' demand for a union shop.
- The Hospital's broad management rights provision.
- A sizeable difference in the amount compensation being offered by the hospital and that being sought by the Teamsters, on behalf of the nurses.

A decertification petition has been filed with the National Labor Relations Board (NLRB), seeking to remove the Teamsters as representative of the nurses. This petition has not yet been processed by the NLRB. When an election is agreed to, or ordered by the NLRB, the Teamsters must demonstrate majority support in order to continue as the nurses' bargaining representative.

It is important to note that the Employer's proposed contract is of a one-year duration and expires on November 14, 2003. Thus, even if the Employer's proposed contract were ratified today, the bargaining process for a new contract would begin almost immediately.

Information and Perceptions Shared With the Panel

The following represents a summary of comments received in testimony to the Panel:

- In general, the nurses, whether striking or not, received a lot of support and recognition from the community for the hard work they do. The respondents were divided in their views about working nurses versus striking nurses. Although many people believe the community should support the striking nurses, many other people believe that certain professions are inappropriate for striking due to their critical nature (i.e., hospital personnel, police officers, firefighters, etc.)
- Many people expressed fatigue with the advertising (billboards and yard signs) and picketing tactics of the Teamsters and the striking nurses. Many people believe the Teamsters' interest in the nurses is to gain dues-paying members. The pro-union voices want the nurses' representation by the Teamsters honored. The anti-union voices did not believe in the Teamsters demand for a union shop.
- The Panel noted an underlying theme in most of the correspondence received and testimony taken. Most everyone agreed, with the exception of the hospital, that all parties should "return to the table" and reach agreement.
- Above all else, the majority of correspondence echoed the community's sense of division and polarization. Friends and family have turned

against each other, as NMH represents the largest employer in the area and undoubtedly touches many lives. Many people also seemed concerned about the long-term negative effects the strike will have on the community, long after this labor dispute is concluded.

Appendix 1

Northern Michigan Hospital Services and Regional Census Information As Provided by the Michigan Department of Community Health

- NMH is a 243-bed regional referral hospital, which has been in existence for 102 years. Their Cancer Care program is affiliated with Karmanos Cancer Institute in Detroit. Other programs operated by the hospital are:
 - Nisus Research, which has been in existence for 16 years, has given 1,700 patients the chance to participate in over 160 clinical trials studying heart attacks, congestive heart failure, hypertension, diabetes, asthma, kidney disease and arthritis, among others.
 - In partnership with Charlevoix Area Hospital, a long-term care facility/subacute rehabilitation center is available. This facility is called Boulder Park Terrace.
 - Hospice services are provided in conjunction with Hospice of Little Traverse Bay, providing care to families in Emmet, Charlevoix and part of Cheboygan counties.
 - A network of dialysis centers has been formed, operating under the Northern Michigan Regional Health Care System, serving residents in Traverse City, Alpena, and Sault Ste. Marie.
 - Partnering with Community Memorial Hospital (Cheboygan), and Charlevoix Area Hospital, NMH operates a home health service, called Vital Care.
 - A community health and education center is available in Petoskey.
- In 2002, NMH was named one of the Solucent 100 Top Cardiovascular Hospitals. The hospital is the only one north of Grand Rapids receiving this recognition.
- According to the *American Hospital Association 2002-03 Directory*, NMH is considered a general medical/surgical hospital. Its control status is “Nongovernmental/not-for-profit/other”. The hospital reports 219 staffed beds, with 9,380 admissions during the reporting period, and the average census is 117 (excluding newborns). During the reporting period, 832 babies were born at NMH.

- The region includes four counties Emmet, Antrim, Otsego, and Charlevoix; all four counties experienced generally higher than state or national unemployment rates during 2002:

Average¹		High (by month)	Low (by month)
United States	5.8%	6.3% (January)	5.3% (October)
Michigan	6.2%	7.2% (January)	5.4% (October)
Emmet County	7.7%	11.7% (March)	4.6% (Aug./Oct.)
Antrim County	7.8%	10.2% (March)	5.7% (Sep./Oct.)
Charlevoix County	7.7%	10.8% (March)	5.3% (September)
Otsego County	7.2%	9.9% (March)	5.6% (October)

Source: Michigan Department of Career Development, Office of Labor Market Information.

- **FIA Case Loads by County**—These were reported as of May 2003, and generally reflect adults accessing services provided by the Family Independence Agency in each of the four counties:

	Emmet	Antrim	Charlevoix	Otsego
FIP Cases	73	54	54	86
Food Stamp Cases	823	586	665	947
Med. Assist. Cases	2636	1998	2054	2293

- **Local Health Concerns:** Priorities and activities aimed at improving local health status, identified in the Community Health Assessment and Improvement process for 2002, included:
 - **Access to Care**—Dental Clinics North was implemented, with eight clinics operating at the beginning of FY 02. They anticipated serving 20,000 clients through this system of care. The Northern Prescription Discount Plan was begun the previous year. A total of 1,072 persons were enrolled in the plan, saving an estimated \$75,943 in year one across the four-county area. The Northern Michigan Health Plan was formed in collaboration with four other local health departments, and three hospitals serving the area. Uninsured benchmark data were: in 1995, 10.5% of the residents were uninsured; this figure was reduced to 10.1% in 2000.
- Other information about Emmet County:
 - For the period 1991-2000, preventable hospitalizations were lower than the state averages each year.

¹ These data are not seasonally-adjusted.

- The population of Emmet County, the most populous in the region grew 2.5% between April 1, 2000-July 1, 2001. In contrast, the state population grew .5% during the same time period.

2000 Census Data

Population by Age	Emmet County	Michigan
% under age 5	6.2%	6.8%
% under age 18	25.3%	26.1%
% age 65 and over	14.3%	12.3%
Caucasian	94.3%	80.2%
African American	.5%	14.2%
Hispanic/Latino	.9%	3.3%
American Indian/Alaska Native	3.1%	.6%
HS Grad % aged 25+	89%	83.4%
Bachelors or higher, age 25+	26.2%	21.8%
Home Ownership rate	75.6%	73.8%
Median Home Value (2000)	\$131,500	\$115,600
Percent below poverty (1999)	7.4%	10.5%
Persons with a disability, age 5+	4,929	1,711,231

- The *Community Health Status Report*, published by HRSA in July 2000 for Emmet County, showed the following leading causes of death by age group for Caucasians only (numbers in other race categories are too small to be statistically significant):

Illness	Ages 25-44	Ages 45-64	Ages 65+
Injuries	26%		
Suicide	17%		
Cancer	13%	33%	22%
Heart Disease	12%	30%	35%

- Life expectancy in the county was 75.4 years in 1990, which was the median rate for all US counties.
- Using HRSA's peer county analysis, the following measures of birth and death were noted as needing further study/possible reduction:

Premature Births	Emmet County	10.0%
Births (<37 weeks)	Peer County Range	8.1-11.2%
Older Mothers, 40+	Emmet County	1.5%
	Peer County Range	0.7-2.1%
Vehicle Injuries	Emmet County Rate ²	29.3

² Age-adjusted to year 2000 standard, per 100,000 population.

	Peer County Range	16.2-29.3
Suicide	Emmet County Rate	15.9
	Peer County Range	7.5-17.1

- Compared to both peer counties and the United States rates, Emmet County was deemed favorable in the following areas: Very low birth weight (<1500 grams), Low birth weight (<2500 grams), Teen mothers (< 18 years old), Unmarried mothers, No care in first trimester, Infant mortality, White infant mortality, Neonatal infant mortality, Female breast cancer, Colon cancer, Coronary heart disease, Lung cancer, Stroke and Unintentional Injury.
- During the period April 1, 2000-July 1, 2001, Antrim County's population grew 2.2% and comparing 1990 census data to 2000 census data, the increase was 27.1%. The percentage of population below poverty, in 1999, was 9%.
- Charlevoix County's population also grew between April 1, 2000-July 1, 2001, but only by 1.4%. Comparing 1990 and 2000 census data, the population increased 21.5% and the percentage of persons below poverty (1999) was 8%.
- Finally, Otsego County's population increased 2.2% during the period 4/1/00-7/1/01. Comparing 1990 and 2000 census data, the county's population increased by 29.8% and the percentage of persons below poverty in 1999 was 6.8%.

Appendix 2

According to *Kids Count in Michigan* (2001), the following statistics were reported relative to children in the four-county area:

Children Receiving FIP Support (Family Independence Program)

Statewide:	5.4%	Of 83 Counties:
Emmet:	1.1%	Rank: 6
Charlevoix:	1.5%	Rank: 7
Otsego:	1.9%	Rank: 16
Antrim:	1.9%	Rank: 18

Children Receiving Food Stamps (age 0-18)

Statewide:	12.3%	
Emmet:	4.9%	Rank: 6
Charlevoix:	5.9%	Rank: 10
Antrim:	6.4%	Rank: 15
Otsego:	9.2%	Rank: 28

Children Insured by Medicaid (age 0-18)

Statewide:	23.6%	
Emmet:	19.5%	Rank: 18
Charlevoix:	22.5%	Rank: 26
Antrim:	24.5%	Rank: 36
Otsego:	25.8%	Rank: 43

MIChild Coverage

Statewide	1%	
Emmet:	2%	Rank: 76
Charlevoix:	1.9%	Rank: 73
Otsego:	1.8%	Rank: 64
Antrim:	1.6%	Rank: 58

Children Receiving SSI (age 0-17)

Statewide rate is 12.3 per 1,000

Emmet:	5.5/1,000	Rank: 9
Charlevoix:	7.1/1,000	Rank: 17
Antrim:	8.2/1,000	Rank: 26
Otsego:	9.1/1,000	Rank: 33

In all four counties, the percentages of children born with birth defects were below the state average.

Appendix 3

Report From the Teamsters Local 406 Regarding Northern Michigan Hospital (Cost Exhibit 1)

**NURSING STRIKE EXPENSES
NORTHERN MICHIGAN HOSPITAL**

WAGE COMPARISON FOR ONE WEEK*

Regular NMH Nursing Staff

Straight Time (40.00 hrs.)	40 hrs. X \$22.00 = \$880.00
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Overtime (20 hrs.) @ time and one half 20 hrs. X \$33.00 = \$660.00

U.S. Nursing Corp. Nurses

Straight time (40 hrs.)	40 hrs. X \$40.00 = \$1,600.00
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Overtime (20 hrs.) @ time and one half 20 hrs. X \$60.00 = \$1,200.00

*Replacement nurses are guaranteed 60 hrs. per week.

Appendix 3 (continued)**Report From the Teamsters Local 406 Regarding Northern Michigan Hospital
(Cost Exhibit 3)****ESTIMATED COST TO NMH
REPLACEMENT RN'S (RRN) FROM
November 14, 2002 - July 14, 2003***

Wages - calculated for 150 RRN @ \$40.00/hr 20 hrs. of overtime @ 60/hr	\$14,560,000.00
Lodging - calculated for 150 RRN's @ \$50.00/night (75 rooms) 2 nurses per room *cost is artificially low now for the resort season	910,000.00
Meals - calculated for 150 RRN's @ \$25.00/day	910,000.00
Total	\$16,380,000.00
Wages for Regular NMH RN's	7,392,000.00
Difference	\$ 8,988,000.00

*The above does not include the following real costs

1. The contract fee paid to U.S. Nursing Corp
2. Security guards
3. The Fishman Group Law Firm
4. Other professionals
5. Travel expenses for RRN's to and from Petoskey
6. Transportation expenses for RRN's to and from NMH each day

Appendix 4

Financial Data - Michigan Department of Community Health

Calendar Year 2000 Data

Total Beds	213
Total Occupancy	48.07%
Medicare Occupancy	26.44%
Medicaid Occupancy	2.29%
Medicare Utilization	54.99%
Medicaid Utilization	4.77%
Inpatient Medicaid Revenue	\$5,561,790
Outpatient Medicaid Revenue	\$2,971,975
TOTAL Medicaid Revenue	\$8,533,765
Medicaid as a % of Total Revenue	5.11%

Calendar year 2001 Data

Total Beds	213
Total Occupancy	51.10%
Medicare Occupancy	27.20%
Medicaid Occupancy	4.86%
Medicare Utilization	53.23%
Medicaid Utilization	9.51%
Inpatient Medicaid Revenue	\$7,276,021
Outpatient Medicaid Revenue	\$3,629,269
TOTAL Medicaid Revenue	\$10,905,290
Medicaid as a % of Total Revenue	5.91%

